

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013113

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2399

STATE FILE NUMBER

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in lb

OR
TOWN St. Louis

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION 3026 Cass Avenue

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY
OR
TOWN St. Louis

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

3026 Cass Avenue

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Washington

Middle

CHEAIRS

Last

4. DATE

Month

Day

Year

OF
DEATH Feb. 26, 1963

5. SEX

Male

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☒Widowed ☐ Divorced ☐

8. DATE OF BIRTH

1/1/98

9. AGE (last birthday)

65

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Memphis, Tenn.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Gilbert Cheairs

13b. MOTHER'S MAIDEN NAME

Adaline - Unk.

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mary Wright, 3026 Cass Ave.

18. CAUSE OF DEATH (Enter only one cause per
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic Myocarditis

Arterio-sclerosis

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

4224

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Death occurred at

935 A

and last saw her
him alive on

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

1300 Clark

22c. DATE SIGNED

3-3-63

23. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

3/4/63

23c. NAME OF CEMETERY OR CREMATORY

Washington Park Cem.

23d. LOCATION (City, town, or county)

Berkeley City, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Estella White, 2616 N. Garrison

25. DATE RECD. BY LOCAL REG.

MAR 4 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

RATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300
Rev. 4/59

1

2 221

3

4 2

5 0

6

7 1

8 2

9

10

11

12 90-3

13

90

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.